FOR IMMEDIATE RELEASE

HUMAN RIGHTS AUTHORITY- CHICAGO REGION

REPORT 10-030-9020
Swedish Covenant Hospital

Case Summary: The HRA substantiates the complaint that the hospital did not follow Code procedures when it restrained a recipient and administered forced psychotropic medication. The provider response follows.

INTRODUCTION

The Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission opened an investigation after receiving a complaint of possible rights violations at Swedish Covenant Hospital in Chicago. It was alleged that the hospital did not follow Code procedures when it restrained a recipient and administered forced psychotropic medication. If substantiated, these allegations would violate the Mental Health and Developmental Disabilities Code (405 ILCS 5/100 et seq.) and hospital policies.

Swedish Covenant Hospital is an independent, nonprofit teaching hospital under the auspices of the Evangelical Covenant Church, and it incorporates a 25-bed Behavioral Health Unit.

To review these complaints, the HRA conducted a site visit and interviewed the Associate General Counsel, the Behavioral Health Nurse Manager, two Nurse Managers, the Social Worker, the Psychiatric Case Manager, and two resident physicians. Relevant program policies were reviewed as were the recipient's records upon written consent. The recipient is an adult.

COMPLAINT SUMMARY

The complaint states that a recipient was taken to Swedish Covenant Hospital on 2/09/10, and told that he would be there for only two days. Allegedly, the recipient refused medication and was then administered forced psychotropic medication and placed in restraints, where he remained for a day and a half. The recipient was discharged on 2/17/10.

FINDINGS

The record (emergency room chart) shows that the recipient was taken by police to Swedish Covenant Hospital on 10/09/10 at 8:15 p.m. The record offers the following narrative of the presenting complaint: "Domestic issue at home with brothers and sister. Stated, 'She stole my bankbook.' Physically and verbally abusive. Took father's 02 tank and threw it into window. Denies suicidal ideation. I don't want to kill my brother I just want to push him over. Denies hearing voices…" At 8:10 p.m. there is an entry that states, "Alert not in distress, ER resident at bedside. Patient refusing to get undressed at this time, explained that he has to as a policy hospital [sic]…." The recipient was then triaged in the emergency room and at 8:34 p.m. he was given a mental health assessment by a crisis worker. Notes from this assessment state that the recipient's general appearance, mood, and thought content are appropriate, and that there is no sign of homicidal or suicidal ideation. At 10:14 the record indicates that the recipient, "Verbalized desire to go home. 'I have people depending on me and I'm going home.' Security called to bedside for elopement precaution." The entry for 10:50 p.m. states, "Security called to bedside to start an IV and give medicine to patient. 'No you're not putting anything on me and I'm going home.' Told patient he's staying in the hospital for his elevated blood sugar. 'I'm not staying and you're not putting anything on me, I'll sue this hospital.' Patient tried getting out and became very aggressive, swinging at the staffs, does not listen. 'You all lie to me, give me my fucking clothes.' Patient have [sic] to be restrained and sedated with Ativan."

The record contains an emergency physician evaluation, completed at 10:17 p.m. on 2/09/10 which states, "The pt. is persistent in his homicidal ideation and threats to harm his family. For this reason we'll admit him to a state psychiatric unit for psychiatric evaluation and stabilization." This form indicates that the recipient is medically cleared for continued psychiatric evaluation. Hospital staff reported that the attempt was made to transfer the recipient to a state mental health facility, however no beds were available. Then, when the recipient's blood test results were reviewed, the determination was made to begin insulin injections to stabilize his dangerously high glucose level. At 11:47 p.m. the record shows that "Patient pulled out his IV, Heplock started on the rt arm." At 12:18 a.m. the recipient was transferred to a medical floor with a security assist due to a dangerously high glucose level (355 mg/dl) for which he refused all medication. The recipient continued in his refusal of treatment for several days and it is noted in his chart by the resident physician on 2/12/10 "Transfer to a Psych floor since pt. refuses any medical treatment. Continue restraints." The record does not contain a mental health treatment plan for the recipient, and he was not seen by a psychiatrist except for a psychiatric consultation on 2/10/10 at 1:33 p.m. which offers the following diagnosis: "Axis I: Rule out bipolar disorder, manic; Axis II Deferred; Axis III: History of hypertension and diabetes currently; Axis IV: Primary Support issues." The recipient remained on the medical unit until 2/17/10 when he was transferred to a state mental health facility.

The record contains a petition, completed on 2/09/10 (the time is not given) by the hospital crisis worker, which describes the recipient's presenting behaviors, signs, and symptoms: "Respondent was brought by CPD after niece called because respondent had thrown his father's oxygen tank. Respondent says he did this to demonstrate what he would do to his brother. Respondent said, 'If he'd been there I'd have killed him- beat him up so he's have to lie in the hospital. He added, 'That's why I get medicine; I'm lucky I haven't killed anybody.'" The petition does not include the time of its completion and does not indicate that the recipient was given a copy of the petition within 12 hours. It also does not indicate that the recipient was given

a statement of his rights. A certificate is included in the record and indicates that it was completed by an emergency room physician at 10:45 p.m. on 2/09/10. The clinical observations and factual information on which the certificate is based states, "Patient threatening harm to family members, threw father's oxygen tank out window tonight, admits to uncontrollable anger. Patient presents with poor impulse control, inability to contract for safety re harming family members." There is no second certificate in the record, and the petition and certificate were not filed with the court.

The emergency room record shows that at 12:02 a.m. on 2/10/10 the recipient was placed in four-point restraints. An accompanying Restriction of Rights Notice is included in the record however the area indicating the length of time is not completed. The reason given is "Verbally abusive, aggressive, swinging at staffs, unable to follow [sic]." It indicates that the recipient wanted no one notified. There are 4 physician orders for restraint in the record beginning at 11:00 p.m. (the emergency room record was completed after the restraint episode began, thus a discrepancy in the time of the initiation of restraint) on 2/09/10. The first order describes the recipient's behavior as "aggressive, swinging at staff, verbally abusive, and undirectable." The duration is 4 hours and it includes a continuation for an additional 4 hours. The physician assessment, which indicates an evaluation of the recipient's medical condition as affected by the restraints, states, "Attacked ED staff- hit, kicked, wrestled." The second order is written at 7:30 a.m. on 2/10/10 for 4 hours. The behavior is, "Aggressive, continue to make threats to kill others." There is no statement of the recipient's medical condition as affected by the restraint, and it is also continued for 4 hours. The third order is written at 11:30 p.m. on 2/10/10. The reason is, "Agitated, fighting physically with staff." There is no physician statement of the recipient's medical condition as affected by the restraints on this order and it is continued for another 4 hours, and the restraint has been changed to the recipient's lower extremities only. The final order is written at 7:30 a.m. on 2/11/10. The reason is "agitated, threatened to hit, verbally abusive." The duration is 4 hours and there is no physician statement of the recipient's medical condition as affected by the restraint. Although the physician orders indicate that the recipient came out of restraints between the second and third order, the restraint flow sheet shows that the recipient remained in restraints for 35 hours.

The record contains a restraint flow sheet which indicates that the recipient was placed in restraints at 12:00 a.m. on 2/9/10 and continued until 11:15 a.m. on 2/11/10. It also shows that checks were made of the recipient each 15 minutes and that every two hours the recipient was checked for hygiene/elimination, hydration/nutrition, range of motion, and outcome, none of which indicate any injury or harm to the recipient. There is also an area to indicate the recipient's behavior while in restraint, as well as his level of awareness. These areas indicate that for much of the recipient's last day in restraints he was quiet and sleeping.

The Medication Discharge Summary shows that the recipient was given Ativan 2 mg by injection on 2/09/10 at 11:00 p.m. and Haldol, 5 mg on 2/10/10 at 4:16 p.m. (for agitation and aggression). The record contains a Clinical Documentation Module which describes the recipient's behaviors and hospital interventions. It shows that on 2/10/10 the patient was refusing all medication and demanded to be released from restraints. At 4:05 p.m. he was given Ativan with security assist. At 7:40 p.m. he was again injected with Haldol 2 mg and Ativan 2 mg, again with security assist. On 2/13/10 the recipient was threatening to leave the hospital and was

injected with Haldol 5 mg. The record does not contain Restriction of Rights Notices for the forced medication or a physician's statement of decisional capacity. Additionally there is no identified Preferences for Emergency Treatment form or consents for medication. Medications administered at the request of the recipient (PRN) are noted as such in the record.

Hospital staff were interviewed concerning the complaint. They stated that the recipient was brought into the emergency room by police and was very angry and aggressive from the onset. He was then triaged and given a mental health assessment by a crisis worker and found to be appropriate for involuntary admission as a mental health recipient. In the meantime the recipient's blood test results were reviewed and it was recognized that he had a dangerously high glucose level and required medical stabilization on insulin. At this point the recipient was threatening to leave the hospital and staff felt this presented a danger to the recipient, along with the danger he presented to his family from his uncontrolled anger and aggression. When a bed was not available at the state mental health facility, the recipient was transferred to the medical unit to address the glucose level. Hospital representatives stated that staff on the medical unit would not have addressed the recipient's rights as an involuntary admittee. Thus, issues surrounding the petition, certificates, and information regarding recipient rights would not be handled there. Hospital representatives stated that they realize this issue needs to be considered, and they are addressing it administratively. A possible solution is that a case manager from the psychiatric unit could be assigned to a recipient on the medical unit if a recipient requires medical intervention.

Hospital staff were asked if the recipient's high glucose level could have caused his aggression and anger, and thus could have been managed with less restrictive alternatives. They stated that the high blood sugar might have been a contributing factor to the recipient's aggression, however it might have been dangerous to wait and calm the recipient before addressing the medical problem.

Hospital staff were asked about the prolonged restraint episode. They stated that they realized after the complaint was issued that perhaps the restraint intervention could have been handled differently, and they immediately began a training inservice to reduce the use of restraints altogether. Due to this education they have reduced their reliance on restraint considerably. They have also addressed the use of Restriction of Rights Notices and will complete one for each time that a recipient's rights are restricted.

STATUTORY BASIS

The Mental Health Code describes a "mental health facility" as "…any licensed private hospital, institution, or facility or section thereof, and any facility, or section thereof, operated by the State or a political subdivision thereof for the treatment of persons with mental illness and includes all hospitals, institutions, clinics, evaluation facilities, and mental health centers which provide treatment for such persons" (405 ILCS 5/1-114).

The Mental Health Code states that when a person is asserted to be in need of immediate hospitalization, any person 18 years of age or older may complete a petition (5/3-600), which specifically lists the reasons (5/3-601). The petition is to be accompanied by the certificate of a qualified examiner stating that the recipient is in need of immediate hospitalization. It must also contain the examiner’s clinical observations and other factual information that was relied upon in

reaching a diagnosis, along with a statement that the recipient was advised of certain rights (3-602), including that before the examination for certification the recipient must be informed of the purpose of the examination, that he does not have to speak with the examiner, and that any statements he makes may be disclosed at a court hearing to determine whether he is subject to involuntary admission (5/3-208). Upon completion of one certificate, the facility may begin treatment, however at this time the recipient must be informed of his right to refuse medication (3-608). As soon as possible, but no later than 24 hours after admission, the recipient must be examined by a psychiatrist or released if a certificate is not executed (5/3-610).

The Mental Health Code allows for treatment without consent in the case of a mental or dental emergency, that is, when delay for the purpose of consent would "endanger the life or adversely affect the health of a recipient of services." A medical or dental emergency is determined by a physician after examining the recipient and determining that the recipient is not capable of giving informed consent (5/2-111).

The Mental Health Code guarantees all recipients adequate and humane care in the least restrictive environment. As a means to this end, it outlines how recipients are to be informed of their proposed treatments and provides for their participation in this process to the extent possible:

"(a) A recipient of services shall be provided with adequate and humane care and services in the least restrictive environment, pursuant to an individual services plan. The Plan shall be formulated and periodically reviewed with the participation of the recipient to the extent feasible and the recipient's guardian, the recipient's substitute decision maker, if any, or any other individual designated in writing by the recipient…. In determining whether care and services are being provided in the least restrictive environment, the facility shall consider the views of the recipient, if any, concerning the treatment being provided. The recipient's preferences regarding emergency interventions under subsection (d) of Section 2-200 shall be noted in the recipient's treatment plan. [Section 2-200 d states that recipients shall be asked for their emergency intervention preferences, which shall be noted in their treatment plans and considered for use should the need arise].

(a-5) If the services include the administration of…psychotropic medication, the physician or the physician's designee shall advise the recipient, in writing, of the side effects, risks, and benefits of the treatment, as well as alternatives to the proposed treatment, to the extent such advice is consistent with the recipient's ability to understand the information communicated. The physician shall determine and state in writing whether the recipient has the capacity to make a reasoned decision about the treatment. …. If the recipient lacks the capacity to make a reasoned decision about the treatment, the treatment may be administered only (i) pursuant to the provisions of Section 2- 107 [to prevent harm]…." (405 ILCS 5/2-102).

Should the recipient wish to exercise the right to refuse treatment, the Mental Health Code guarantees this right unless the recipient threatens serious and imminent physical harm to himself or others:

"An adult recipient of services…must be informed of the recipient's right to refuse medication… The recipient…shall be given the opportunity to refuse generally accepted mental health or developmental disability services, including but not limited to medication... If such services are refused, they shall not be given unless such services are necessary to prevent the recipient from causing serious and imminent physical harm to the recipient or others and no less restrictive alternative is available. The facility director shall inform a recipient…who refuses such services of alternate services available and the risks of such alternate services, as well as the possible consequences to the recipient of refusal of such services" (405 ILCS 5/2-107).

Additionally, the Code states that whenever any rights of the recipient of services are restricted, notice must be given to the recipient, a designee, the facility director or a designated agency, and it must be recorded in the recipient's record (ILCS 405 5/2-201).

Restraint is a therapeutic tool that the Mental Health Code carefully regulates. Although its use is to prevent physical harm, the Code outlines specific measures to ensure that it is safe and professionally applied:

"Restraint may be used only as a therapeutic measure to prevent a recipient from causing physical harm to himself or physical abuse to others. Restraint may only be applied by a person who has been trained in the application of the particular type of restraint to be utilized. In no event shall restraint be utilized to punish or discipline a recipient, nor is restraint to be used as a convenience for the staff.

(a) Except as provided in this Section, restraint shall be employed only upon the written order of a physician, clinical psychologist, clinical social worker, or registered nurse with supervisory responsibilities. No restraint shall be ordered unless the physician, clinical psychologist, clinical social worker, or registered nurse with supervisory responsibilities, after personally observing and examining the recipient, is clinically satisfied that the use of restraint is justified to prevent the recipient from causing physical harm to himself or others. In no event may restraint continue for longer than 2 hours unless within that time period a nurse with supervisory responsibilities or a physician confirms, in writing, following a personal examination of the recipient, that the restraint does not pose an undue risk to the recipient's health in light of the recipient's physical or medical condition. The order shall state the events leading up to the need for restraint and the purposes for which restraint is employed. The order shall also state the length of time restraint is to be employed and the clinical justification for that length of time. No order for restraint shall be valid for more than 16 hours. If further restraint is required, a new order must be issued pursuant to the requirements provided in this Section….

(c) The person who orders restraint shall inform the facility director or his designee in writing of the use of restraint within 24 hours.

(d) The facility director shall review all restraint orders daily and shall inquire into the reasons for the orders for restraint by any person who routinely orders them.

(e) Restraint may be employed during all or part of one 24 hour period, the period commencing with the initial application of the restraint. However, once restraint has been employed during one 24 hour period, it shall not be used again on the same recipient during the next 48 hours without the prior written authorization of the facility director.

(f) Restraint shall be employed in a humane and therapeutic manner and the person being restrained shall be observed by a qualified person as often as is clinically appropriate but in no event less than once every 15 minutes. The qualified person shall maintain a record of the observations. Specifically, unless there is an immediate danger that the recipient will physically harm himself or others, restraint shall be loosely applied to permit freedom of movement. Further, the recipient shall be permitted to have regular meals and toilet privileges free from the restraint, except when freedom of action may result in physical harm to the recipient or others…. (405 ILCS 5/2-108).

HOSPITAL POLICY

Swedish Covenant Hospital policies (08-630-53 Admission- Adult Voluntary) and (08-630-54 Admission Adult Involuntary) protect the rights of patients as recipients within the behavioral health unit as outlined in the Mental Health Code. However there is no policy to

address patients who are admitted involuntarily in the emergency department and then transferred to the medical floor involuntarily.

Swedish Covenant Hospital policy (01-951-17 Consent to Treatment) states that a patient should not be subjected to any procedure without his understanding and voluntary consent. In general, an adult with decisional capacity may refuse medical treatment: "Regardless of the reason for refusal, the patient's wishes must be respected." The policy defines decisional capacity as "the ability to understand and appreciate the nature and consequences of a decision regarding medical treatment…and the ability to reach and communicate an informed decision in the matter as determined by the attending physician." The policy notes that a diagnosis of mental illness, of itself, is not a bar to a determination of decisional capacity. The exception is a medical emergency, when delay for the purpose of consent endangers the patient's life or safety, and then a physician may undertake the required procedure without consent.

Swedish Covenant Hospital policy (08-630-101 Refusal of Medication) states that patients have the right to refuse medication unless a court has ordered involuntary medication or the medication is necessary to prevent the patient from causing serious and imminent harm to himself or others and no less restrictive alternative is available. If a patient escalates in harmful behavior and refuses medication, the patient should be directed to his room and offered less restrictive measures. If the behavior continues to escalate despite these measures, then the patient should be warned that medications will be given involuntarily to maintain safety. The policy also directs that whenever an involuntary medication is given, a Restriction of Rights Notice must be issued.

Swedish Covenant Hospital policy (08-111-11 Restraint Usage) states that restraints are used "only when medically necessary to protect the patient from injury and/or to protect the patient from injuring others, after alternatives and less restrictive measures have been attempted and deemed ineffective." These alternatives to restraint are to be attempted and documented prior to the initiation of restraints. Restraint for behavioral management can only be used in emergency situations in which there is "an imminent risk of an individual physically harming themself or others. Additionally, the policy states that clinical leadership (Nurse Manager, Charge Nurse) is notified of instances in which an individual remains in behavioral restraints for more than 12 hours and then an assessment is made to determine if additional staffing resources are necessary "to facilitate discontinuation of restraint or seclusion for violent and self destructive behavior."

The hospital policy for restraint procedures comports with all the Mental Health Code requirements. The policy indicates the duration of the restraint may not exceed 4 hours for patients 18 years and older and requires a new physician order for all restraint episodes and continuances.

CONCLUSION

The recipient in this case was taken to Swedish Covenant Hospital by the police after the recipient's sister reported the recipient having thrown an oxygen tank through a window. The recipient was not arrested or held for questioning, so police made an initial assessment that he

was in need of a mental health evaluation. The comments of the crisis worker who assessed the recipient at 8:34 p.m. on 2/09/10 describe the recipient as "appropriate" with "no suicidal/homicidal ideation," however this quickly changed when he was told not only that he could not go home, but also that he could not refuse medication, which was then administered with a security assist. By 12:02 a.m. on 2/10/10 the recipient was also placed in restraints and medicated and was then held involuntarily on the medical floor to treat his elevated blood sugar and concurrently his anger problem for an additional 8 days.

The record shows that the recipient refused treatment from the time he stated that he wanted to go home, at approximately 10:14 p.m. on 2/09/10. He was prevented from leaving by the presence of security and forced psychotropic medication, then at approximately 10:45 p.m. a petition and certificate were provided which authorized his involuntary admission as a mental health recipient. Unfortunately he was not provided with his rights information, the petition was incomplete, and a second certificate was not completed because he had been moved to a medical floor in the interim, still unable to leave. The petition was not ever filed with the court and the recipient was never given a copy of the petition, all mandated by the Mental Health Code's authority to detain someone. On the medical floor he was not given a treatment plan and was not seen by a psychiatrist, except for a consultation. He was given forced psychotropic medication without being given Notice of Rights Restrictions, there is no physician's decisional capacity statement in the clinical record, and there is evidence of informed consent, all requirements of the Code.

The record shows that the recipient was placed in restraints for over 35 hours and only one Restriction of Rights Notice was filed for these events and it is not complete, and the record contains no Preferences for Emergency Treatment. The record does not show that restraints were implemented "after alternatives and less restrictive measures have been attempted and deemed ineffective" as stated in the hospital policy. Although the hospital asserts that the recipient was held due to his dangerously high blood glucose level, the record shows that from his entry into the hospital he was clinically diagnosed as a mental health recipient, his treatment recommendation was a transfer to a state mental health facility, and he was medically cleared in order to accomplish this. It is not clear from the record why the recipient was sent to the medical floor but it is doubtful that a 35 hour restraint could ever be perceived as humane or therapeutic, especially when the restraint documentation states that the recipient was asleep and quiet for hours at a time. Finally, the recipient was not evaluated by clinical leadership after 12 hours in restraint as per hospital policy and the restraint was continued beyond 24 hours without the director's signed approval, which violates hospital policy and Mental Health Code standards.

The HRA substantiates the complaint that the hospital did not follow Code procedures when it restrained a recipient and administered forced psychotropic medication.

RECOMMENDATIONS

1. Develop policy and procedure which is specific to the admission and emergency treatment of mental health recipients. Develop and train staff in procedures that specifically address the mentally ill recipient and guarantee these rights according to the Mental Health and Developmental Disabilities Code (405 ILCS 5/100 et seq.).

2. Although the recipient was held as a mental health recipient for 8 days, he was not given a treatment plan to address the clinical issues for which he was detained (anger, aggression, etc.). Ensure that mental health recipients are provided with adequate and humane care and services in the least restrictive environment pursuant to an individual services plan which considers the views of the recipient to the extent feasible (405 ILCS 5/2-102 a).

3. The recipient in this case was prescribed (and at times, refused) both psychotropic medication as well as prescribed diabetes medication, yet there are no consents for medication in the record. Ensure that absent an emergency, recipients are advised in writing of the side effects, risks, benefits and alternatives to prescribed medications, and that the physician determines and states in writing whether the recipient has the capacity to make a reasoned decision about this medication (5/2-102 a 5). Should the recipient refuse consent, note this refusal in the record.

4. Ensure that in all instances, forced medications and other treatments are given only to prevent serious and imminent physical harm and that all staff persons understand and follow this Code requirement (405 ILCS 5/2-102, 107).

5. Ensure that recipients are given the opportunity to select preferences for emergency treatment and that the facility gives due consideration to these preferences should the need arise (405 ILCS/5/2-200 d).

6. Instruct all staff members that Notices must be completed, issued, and entered into patient records whenever a recipient's right to refuse treatment is restricted (5/2-201).

7. The Code requires that restraint may not continue for longer than 2 hours unless within that time a nurse or a physician confirms, in writing, following a personal examination of the recipient, that the restraint does not pose undue risk to the recipient's health in light of the recipient's physical or medical condition (405 ILCS 5/2-108). Train staff to include this procedure in their application and documentation of restraint events.

8. The Code requires that once restraint has been employed during one 24 hour period, it shall not be used again on the same recipient during the next 48 hours without the prior written authorization of the facility director. Ensure that staff are trained in this directive and that it is applied to all restraint events (405 ILCS 5/2-108). Also, the hospital policy states that clinical leadership is notified of instances in which an individual remains in behavioral restraints for more than 12 hours and then an assessment is made to determine if additional staffing resources are necessary facilitate an end to the restraint. Instruct hospital staff to follow this directive.

SUGGESTIONS

1. The investigation of this case revealed that the hospital had no authority to hold the recipient against his will and deny his legal right to refuse treatment. Only the proper completion of the petition and two certificates, which are filed with the court in a timely manner allow this intervention and in this case they were not (405 ILCS 5/3-600, 601). Ensure that staff are trained to follow Mental Health Code procedures for the completion of petitions, certificates and filing these documents with the court. Ensure that recipients are informed of their rights as

recipients and that this is signified on the petition and the certificate and noted in the recipient's clinical record (405 ILCS 5/2-200, 5/3-609).

RESPONSE

Notice: The following page(s) contain the provider response. Due to technical requirements, some provider responses appear verbatim in retyped format.

Swedish Covenant Hospital
The science of feeling better

February 28, 2011

Jill Quinto, HRA Chairperson
Illinois Guardianship and Advocacy Commission
1200 S. 1st Ave. Box 7009
Hines, Illinois 60141

Re: Case # 10-030-9020

Dear Ms. Quinto:

This is the response submitted by Swedish Covenant Hospital to the report of findings dated January 5, 2011. The Hospital had requested additional time to respond to the report, due to the complexity of the issues presented.

We believe that the central issue presented by this case is how to assure compliance with requirements of the Illinois Mental Health and Developmental Disabilities Code (the Code) when a patient who is a recipient of mental health services is hospitalized on a medical/surgical unit (or any other hospital unit other than behavioral health, such as obstetrics, pediatrics, rehabilitation, intensive care, etc.). The majority of patients on such a unit are not recipients. We convened a task force to evaluate how to modify our procedures, including our electronic medical record, to identify patients who are mental health recipients and assure that procedures complying with the Code are applied.

As described below, we developed revisions to certain policies and forms, which are now undergoing review by the Division of Nursing Policy and Procedure Committee and the Hospital Forms Committee. We also developed certain customized screens in our electronic medical record (EMR) system. The first of two mandatory inservices for nursing leadership (charge nurses, nursing managers, nursing directors and nurse educators) was held on Thursday, February 24, with a second scheduled for March. Following approval by the Policy and Procedure Committee and the Forms Committee, nursing staff on each unit will be trained on the new procedures.

The following is the Hospital's response to the specific recommendations (reproduced in italics below) in the report. (Please note that the attachments demonstrating new screens to the EMR system do not relate to actual patients, but instead use fictional test names.)

1. *Develop policy and procedure which is specific to the admission and emergency treatment of mental health recipients. Develop and train staff in procedures that specifically address the mentally ill recipient and guarantee those rights according to the Mental Health and Developmental Disabilities Code (405 ILCS 5/100 et seq.).*

Attachment 1 is the draft of Nursing Policy 08-111-02.2, *Mental Health Recipients on a Non-Psychiatric Unit.* Following approval of this policy, nursing staff on units other than the Hospital's

5145 N. California Ave. | Chicago, Il 60625 | T: 773.878.8200 | TTY: 773.989.4855 SwedishCovenant.org

behavioral health unit will be trained on the policy, and the related procedures and forms described below.

2. *Although the recipient was held as a mental health recipient for 8 days, he was not given a treatment plan to address the clinical issues for which he was detained (anger, aggression, etc.). Ensure that mental health recipients are provided with adequate and humane care and services in the least restrictive environment pursuant to an individual services plan which considers the views of the recipient to the extent feasible (405 ILCS 5/2-102 a).*

To identify patients on medical/surgical units who are mental health recipients requiring an individual services plan, the Hospital has developed a screen in the psychosocial assessment section of the EMR. The psychosocial assessment is completed by nursing staff upon admission and by each shift thereafter. If the nurse answers "Yes" to the indicator "Violent?", a screen will open to document the behavioral management intervention. This screen includes short and long term goals for enhancing patient safety and a text box to document the interventions to be used to achieve these goals. Screen prints of these elements are attached as Attachment 2.

3. *The recipient in this case was prescribed (and at times, refused) both psychotropic medication as well as prescribed diabetes medication, yet there are no consents for medication in the record. Ensure that absent an emergency, recipients are advised in writing of the side effects, risks, benefits and alternatives to prescribed medications, and that the physician determines and states in writing whether the recipient has the capacity to make a reasoned decision about this medication (5/2-102 a 5). Should the recipient refuse consent, note this refusal in the record.*

The list of all antidepressant and antipsychotic medications used in the Hospital was obtained from the Pharmacy Department. A custom screen was developed for the Computerized Physician Order Entry (CPOE) function in the EMR, to be triggered whenever one of the listed medications is ordered. If the physician answers "No" to either the statement indicating that the patient consented to use of the medication, or the statement indicating that the patient has the capacity to make a reasonable decision about the medication, a text box will open for the physician to document the nature of the emergency that requires administration of the medication without the consent of a patient with decisional capacity. Physicians will receive training on completion of these new screens.

4. *Ensure that in all instances, forced medications and other treatments are given only to prevent serious and imminent physical harm and that all staff persons understand and follow this Code requirement (405 ILCS 5/2-102, 107).*

Attachment 4 is the draft of Nursing Policy 08-210-01.4, *Refusal of Medication.* Following approval of this policy, nursing staff on units other than the Hospital's behavioral health unit will be trained on the policy, and informed about the physician order changes described above. This attachment also includes the training tool that will be used for training staff on this requirement.

5. *Ensure that recipients are given the opportunity to select preferences for emergency treatment and that the facility gives due consideration to these preferences should the need arise (405 ILCS 5/2-200 d).*

While on the Hospital's behavioral health unit all patients are asked whether they have preferences for emergency treatment, our task force determined this was not practical for all

hospitalized patients on other units. To identify patients on non-psychiatric units who may be mental health recipients and assure that these patients are asked about their preferences for emergency treatment, the Hospital intends to develop a custom screen in the psychosocial assessment portion of the EMR that will be triggered if the nurse answers "Yes" to the indicator "Violent?". This would allow documentation of whether the patient would prefer physical restraint or medication in the event of an emergency requiring protective measures. (Please note that there are no seclusion rooms on units of the Hospital other than the behavioral health unit.) This screen is still in development as of the date of this response.

6. *Instruct all staff members that Notices must be completed, issued, and entered into patient records whenever a recipient's right to refuse treatment is restricted (5/2-201).*

The draft Nursing Policy 08-210-01.4, *Refusal of Medication,* states that the notice of restriction of rights must be completed when involuntary medication is given (please refer to Attachment 4, Procedure 4). To assist in achieving consistent compliance with this requirement, a query screen has also been developed for the EMR to document completion of the restriction of rights form (see Attachment 5). Attachment 5 also includes the staff training tool that has been developed for this requirement.

7. *The Code requires that restraint may not continue for longer than 2 hours unless within that time a nurse or a physician confirms, in writing, following a personal examination of the recipient, that the restraint does not pose undue risk to the recipient's health in light of the recipient's physical or medical condition (405 ILCS 5/2-108). Train staff to include this procedure in their application and documentation of restraint events.*

The Hospital's current order form for behavioral restraints is Attachment 6. We propose to modify this form by adding a new section under the Physician Assessment, as follows:

Assessment by Physician or Charge Nurse I have personally seen and examined the patient and restraint does not pose an undue risk to the patient's health.		
Signature	Date	Time

This modification will require approval of the Hospital Forms Committee. In addition, proposed modifications to the Hospital's Administrative Policy on restraint usage will describe this requirement. Please refer to Attachment 7, page 6.

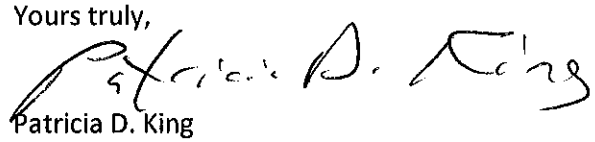
8. *The Code requires that once restraint has been employed during one 24 hour period, it shall not be used again on the same recipient during the next 48 hours without the prior written authorization of the facility director. Ensure that staff are trained in this directive and that it is applied to all restraint events (405 ILCS 5/2-108). Also, the hospital policy states that clinical leadership is notified of instances in which an individual remains in behavioral restraints for more than 12 hours and then an assessment is made to determine if additional staffing resources are necessary to facilitate an end to the restraint. Instruct hospital staff to follow this directive.*

Please refer to the highlighted areas on Attachment 7, page 7. Attachment 8 includes a tool for nursing leadership to assist in monitoring of restraint practices and compliance with the revised policies.

In addition to the eight recommendations set forth above, the Human Rights Authority report also included the suggestion that staff be trained to follow Mental Health Code procedures for completion of petitions and certificates, and filing of these documents with the court. While staff on the Hospital's behavioral health unit are familiar with these documents, staff on other units rarely encounter them and have been unaware of the requirement for filing with the court. To assure that patients who have been admitted to a medical/surgical or other non-psychiatric unit with a petition and certificate are identified and referred to staff trained in mental health procedures, we plan to add a line to the admitting nursing assessment in the EMR for the nurse to document if the patient has been admitted with a petition for involuntary admission. (This custom screen is under development.) If this indicator is checked, it would automatically trigger a social service referral. In the near future, social workers from our behavioral health unit will conduct an inservice with social workers from other units to assure they are familiar with the Code's requirements.

Please contact me if there are additional questions or observations concerning this case.

Yours truly,



Patricia D. King
Associate General Counsel